Medicare Prescription Drug, Improvement, and Modernization Act of 2003

COMPETITIVE BIDDING FOR LOCAL MEDICARE ADVANTAGE PLANS

Section 222

Members of Congress and federal employees have access to a range of private plan options, administered through an annual competitive bidding process. By moving Medicare's private plan program to a more market-based approach that is consistent with the way plans do business in the commercial sector, they should find Medicare contracting more in keeping with their general business practices. In addition, by tying benchmark amounts, described below, to the increased capitation rates provided for in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), private plans should have more resources, which should make Medicare contracting a more viable line of business. These changes are designed to make a wider range of private plan choices available to Medicare beneficiaries.

Local MA Plans

- The MMA creates two types of Medicare Advantage (MA) plans: regional and local plans. Regional MA plans must serve all parts of a geographic region and must have a network of providers but also provide reimbursement for the services of non-network providers. The MMA further stipulates that there must be at least 10 and no more than 50 regions covering the 50 states and the District of Columbia. Local plans can serve smaller geographic areas and a local network plan (e.g., a closed panel HMO) may choose not to provide reimbursement for services provided by non-network providers.

- MA organizations are required to provide at least one plan with prescription drug coverage. They may also offer plans with no drug coverage for beneficiaries who choose not to enroll in Part D of Medicare. With respect to Part D coverage, the rules for prescription drug coverage in MA plans, including those for bidding and payment, are similar to those for stand-alone prescription drug plans (PDPs).

- In general, the MMA requires local MA plans (except Medical Savings Accounts (MSAs)) to use a competitive system for Part A and Part B benefits, beginning with the 2006 contract year. The basic elements of the bidding system are benchmarks, bids, and a comparison of bids and benchmarks for purposes of determining (1) beneficiary rebates (if bid is lower than the benchmark) or premiums for those benefits (if bid is higher than the benchmark) and (2) plan payment amounts for Part A and B benefits.

Benchmarks

- The Secretary determines benchmark amounts for benefits covered by Parts A and B for geographic areas. These are based on the M+C capitation rates as modified by the MMA.

- The Secretary announces benchmark amounts and risk adjustment factors and related information by the first Monday in April.

Plan Bids

- Plans submit a 3-part bid by the first Monday in June addressing (1) Medicare Part A and B benefits (with cost sharing required for Part A and B services or an actuarially equivalent amount), (2) Part D (basic prescription drug) benefits, and (3) supplemental benefits (i.e., reduction in cost sharing for Part A and B benefits, enhancement to the basic drug package, and additional health care benefits). Bids must also include information on the actuarial bases for bids.

- With respect to bids, the Secretary may accept only bid amounts that are supported by the actuarial bases provided by the MA organization. The Secretary has negotiating authority similar to the authority of the Director of the Office of Personnel Management under the Federal Employees Health Benefits Program (this authority does not apply to bids from private FFS plans).

- In order to determine beneficiary rebate amounts (if any), the Secretary compares the plan's bid for Part A and B benefits to the benchmark (which is for Part A and B). If the risk-adjusted bid is lower than the risk-adjusted benchmark, a rebate of 75% of the difference is available to the plan to provide supplemental benefits (described above) or a reduction in the prescription drug, supplemental, or Part B premium.

Beneficiary Premiums

- The determination of a plan's basic premium (if any) also involves a comparison of the bid to the benchmark. If the plan's unadjusted bid for Part A and B benefits is higher than the unadjusted benchmark, the plan's basic premium is the difference between the unadjusted bid and the unadjusted benchmark.

- Beneficiaries may choose to have plan premiums withheld from their Social Security check, through an electronic funds transfer mechanism, or other means the Secretary may specify including payment by an employer.

- Premiums for Part A and B benefits (if any), prescription drug benefits, and supplemental benefits must be the same for all enrollees within the same plan and region, except if employer/union negotiates a different benefit package, in which case the premiums for those retirees would be uniform.

Medicare Plan Payments

- With respect to Medicare payments to the plan,

    - If the plan bid is lower than the benchmark, the Medicare payment amount for Part A and B benefits is the portion of the 3-part bid for Medicare Part A and B benefits (subject to risk adjustment for individual enrollee demographic and health status factors) plus the rebate amount (except rebates related to the Part B premium).

    - If the bid is equal to or higher than the benchmark, the Medicare payment is the benchmark amount, also subject to risk adjustment. If the bid is higher than the benchmark, the plan must charge a basic premium (described above). If it charges a basic premium, the plan also receives an additional payment related to its risk profile.

    - Payments to plans are also adjusted based on the variation in capitation rates among the different local areas included in the region or service area.

- MA plans will receive nearly the same types of payment that stand-alone PDPs will receive, including the direct subsidy, reinsurance, subsidies for low-income beneficiaries, and protections provided by risk corridors. The only difference between payments to MA and stand-alone prescription drug plans is that the MA plans are not allowed to modify the standard risk corridor.

Medical Savings Accounts (MSAs)

- The competitive bidding provisions do not apply to MSAs. MSAs will be paid under the methodology in effect before enactment of this statute, with payments based on MA benchmark amounts.

End-Stage Renal Disease (ESRD) Enrollees

- The Secretary can decide when to implement bid-based payment for ESRD enrollees. Until that time, plans will be paid for their ESRD enrollees under the methodology in effect before enactment of this statute. ESRD enrollees will pay the same premium and receive the same rebates provided to other plan enrollees.

Other Provisions

- The Secretary may not require an MA organization to contract with any specific entity or individual nor can he or she require any particular price structure for payment by plans to entities or individuals.

- Allows the Secretary to waive or modify provisions that hinder the design of, offering of, or enrollment in MA plans offered by employers, labor organizations or the trustees of funds established by employers or labor organizations.

- The Secretary may not approve a plan if he or she determines that the plan's design is likely to substantially discourage enrollment by certain beneficiaries.